

The first 6 chapters of
ADHD: A Path to Success

By

Lawrence Weathers, Ph.D.
Psychologist

6921 E. Jamieson
Spokane, WA 99223
(509) 448-6462, FAX (347) 710-2053
weathers@caer.com, www.caer.com

TABLE OF CONTENTS

Acknowledgments.....10

Warning-Disclaimer.....12

Introduction.....13

Chapter 1: ADHD _ Adaptive, not Defective.....17

Chris a Six-Year-Old Boy with Attention Deficit Hyperactivity Disorder • ADHD Demographics • Myths Of ADHD

Chapter 2: *ADHD: Historical Change in Labeling the Disorder.....25*

Luke, a 14-Year-Old ADHD Boy • ADHD, Current State of the Art Debunked • History of ADHD Labeling and Treatment

Chapter 3: *A Personal Experience of ADHD.....31*

Understanding ADHD Thought Process • We Think Like ADHD Children All of the Time • Your Personal Experience of ADHD • Personal History of ADHD

Chapter 4: *The Conditioned Attentional Avoidance Loop Model.....41*

Developmental Vulnerability to Family Conflict and ADHD • Conditioned Attentional Avoidance Loop Model • Children's Limited View of Time • Avoidance Conditioning: The Horse Grows Bigger

Chapter 5: *ADHD: A Defense Mechanism*.....49

Bob, a 14-Year-Old ADHD Boy • ADHD as a Defense Mechanism • ADHD is Felt as an Insult by Adults • Jane, a 14-Year-Old ADHD Girl

Chapter 6: *Emotional vs. Rational Controls of Behavior*.....57

A Learning Model for ADHD: Conditioned Attentional Avoidance Loop Model • The Conditioned Attentional Avoidance Loop Model Makes Neurological Theories Superfluous • First Get Run Over Emotionally, Then Learn to Run, Attentionally • Fragile Thoughts, Powerful Emotions • Emotions and Rational Decisions • What You Say May not Be What They Hear • Susan, an 8-Year-Old ADHD Girl

Chapter 7: *Attentional Patterns and Behaviors*.....65

Critical Timing of Coercion and Avoidance in the Conditioned Attentional Avoidance Loop Model: Slow Speed of Avoidance Learning vs. Fast Speed for Punishment • Willful vs. Conditioned Attention • Willful Attention • Conditioned Attention • Changing Attentional Patterns is not Like Sports Practice • The Shifting Conditioned-Willful Attentional Balance • ADHD Auto-Pilot • Conjuring Rational Answers to "Why" • The Limitations of Willful Control of Behavior

Chapter 8: *ADHD and Anger*.....77

Cultural Contradiction Both Promotes and Controls Anger • What We Consider "Fun" • Anger as a Part of ADHD • The Conditioned Attentional Avoidance Loop Model and the Development of Anger • Why More Boys Get ADHD • Male Aggression: Social Role of Conflict for Boys • Slower Development of Boys

Chapter 9: *Metamorphosis of Anger in ADHD*.....85

Metamorphosis of Anger from Behavior to ADHD • From Behavior to Personal Trait • Anger Alchemy • The Fiction of Individual Responsibility • The Diagnosis of the ADHD Homunculus

Chapter 10: *Boredom Revisited*.....95

Anger Becomes Depression : The Meaning of Bored • Failure Expectancies in School: No Positive Reinforcement Schedule • "I'm Bored" Means "I Give Up" • Two Meanings of Boredom • How Boredom Works ... For ADHD Kids • The Trap in Defining Boredom in the Adult Sense of the Word for ADHD

Chapter 11: *ADHD in Adults*.....103

Scott ADHD/R

Chapter 12: *Current Explanations of ADHD: Fallacies in Logic*.....105

The Nintendo Syndrome: Situational Specificity of ADHD • A Fancy Test Does Not a Pathology Make • Physiological Cues: PET Studies • Problems with the Logic of PET Studies • The Misuses of Statistics: Correctional Inference • What About Learned Physiological Differences in Neurochemistry? • The Science • Clinical Experience • ADHD Testing: Descriptive vs. Diagnostic • The Bottom-line on the Clinical Relevance of ADHD Testing • Anxious to Diagnose ADHD ... "We've Got to do Something About This" • Opposition to the Ritalin Mandate

Chapter 13: *CAER: A New Treatment Technology*.....121

CAER as Do-It-Yourself Therapy • Unlearning Emotional Patterns vs. Learning New Skills and Knowledge • Emotional Inhibition of Skills

Chapter 14: *The Viewpoint From All Corners*.....127

Seeing With a Different Eye • Looking at the Child, Rather Than the Label • The Child's Experience • What Teachers Say • What Teachers Don't See • What Children Say • ADHD Children are Not Pathological Liars • Carefully Watch the Obvious • Jeff and Kent, Two ADHD Boys

Chapter 15: *Stimulants vs. Conditioned Attentional Avoidance*.....139

Josh, an 11-Year-Old ADHD Boy • The Attentional Function of Stimulant Drugs • The Short Term Utility of Ritalin • Mental Isometrics

Chapter 16: *Thinking Models and ADHD*.....147

A New Approach to Thinking Models We Use and Their Hidden Assumptions • The Mechanical vs. Learning Model of Human Thinking, Feeling, Behavior, and Psychology • The Mechanical Model • The Learning Model • The Learning Model vs. the Educational Model • The Misapplication of Learning and Mechanical Models

Chapter 17: *The Learning Model and the Behavior Amplifier Effect*.....157

Emotional Draw of the Mechanical Model • Confusion Between Mechanical and Learning Models • Treatment Implications of the Mechanical Model Obscures the Learning • The Solution Becomes the Problem • Sean, a 14-Year-Old ADHD Adolescent

Chapter 18: *The Effects of the Broader Cultural Context*.....165

Emotional Contagion: A Mechanism of Socialization • The Contagion Effect of Depression • Crowd Contagion • How Emotional Contagion Works • Which Illusion? • Parents are Slacking Off • The Cultural Context of the Socialization Process • The TV Has ADHD Too! • Teachers in an Impossible Emotional Bind • Loss of Core Self-Inhibitory Skills • Teachers Have Narrow Options to Control Disruptive Behavior • Inspiration in the Classroom: Teachers in an Impossible Bind • Generalized Inhibition in the Classroom • Generalized Inhibition Harms Children Too

Chapter 19: *The Evolution of the ADHD Child*.....181

Creating ADHD • The Personality Conflict Trigger • Karl, an ADHD Boy • Family Stress • Learned Hypersensitivity to Subtle Cues • Teachers Cannot Help Being Part of the Behavior Amplifier • The Behavior Amplifier in Action

Chapter 20: *The Power of Labels*.....189

Labels Create a Self-fulfilling Prophecy • The ADHD Label Shapes Behavior • Labeling Transfers the Problem to New Situations • Transferring the ADHD Label Between Adults • The Child's Generalization of a Strategy That Works • The Label Obscures Small Improvements so More Effective Behaviors are not Shaped

Chapter 21: *The "H" in ADHD*.....197

ADHD as a Service to Other Children • The Self Reinforcing Quality of Hyperactivity • The ADHD Child's Unresponsiveness to Other's Feelings • ADHD Consciousness: A Collage • Junkyard Dog Hyper-Vigilance (Anger)

Chapter 22: *ADHD, Behavior Disabilities, and Learning Disabilities: Branches of the Same Tree*.....203

How ADHD, Behavior Disabilities, and Learning Disabilities Attentionally Avoid Differently • Internal Attentional Strategy • ADHD Takes an Attentional Vacation to Fantasyland • External Behavioral Strategies • Behavior Disabilities Use Chaos to Distract From Being Thought Dumb • Learning Disabilities Use Dumb To Avoid Conflict • How ADHD, Learning Disabilities, and Behavior Disabilities Fit Together in Real Life •

Academic Survival • The Academic Consequences of ADHD and Behavior Disabilities • The Academic Consequences of Learning Disabilities • Adults with ADHD • Tim, 29 Years Old and Learning Disabled

Chapter 23: *Looking Where the Light is: Kid and Medicine*.....217

The Story of the Lost Keys • Advantages of the Conditioned Attentional Avoidance Loop Model

Chapter 24: *Computer Aided Emotional Restructuring: How it Works*.....221

History • Evolution From EMD/R to Computer Aided Emotional Restructuring • How CAER Works • What CAER Looks Like • The Experience of CAER Treatment • Therapeutic Process of CAER

Chapter 25: *Therapeutic Effects of CAER*.....233

What Makes Emotional Extinction so Effective • CAER is a Non-Aggressive Method for Dealing with the Anger • Cognitive Behavior Therapy and CAER • CAER Uses Extinction vs. Cognitive Persuasion • Matt _ An 11-Year-Old ADHD's Experience with CAER

Chapter 26: *The Family System and CAER*.....243

The Stages of Treatment • Parents Baggage ... Carrying it to the Next Generation • Wayne and His Family's Experience with CAER • Parent's Role in the ADHD System • Implications of Parent Treatment • Extinguishing Emotionally Provocative Cues • Extinguishing Parent's Personal Triggers • A Better Functioning Family System

Chapter 27: *The Utility of Boredom Tolerance*.....255

Dealing with Boredom

Chapter 28: *Shaping New Behavior*.....259

A Case For Sudden Change • How Change Can Be Sabotaged • Why? ... The Distinction Between Cause and Maintenance

Chapter 29: *Contingency Management: The U-Shaped Curve*.....265

The Reinforcement Desert • Why the Reinforcement Curve is U-Shaped •

Daniel _ A 9-Year-Old Behavior Problem • Building the Reinforcement Bridge • Why Ritalin Alone Doesn't Work Long-Term • Windows of Opportunity • Missing the Window of Opportunity

Chapter 30: *Discipline*.....277

Abdication of Parenthood • Grounding Children • The Liability Issues of Corporal Punishment • ICBM of Discipline

Chapter 31: *Paving the Way for Rational Problem Solving Approaches*.....285

CAER and Rational Thought · How Learning Access Tutoring Works · Resolving Blocks to Learning · Who is Learning Access For?

Chapter 32: *A Final Note*.....289

Within the Solution was the Solution

Epilogue.....291

Appendix.....297

Bibliography.....303

Index.....309

About the Author.....315

Introduction

Life Through the Eyes of an Attention Deficit Hyperactivity Disorder Child

With terror in my heart, I can still remember sitting in emotional and almost physical pain at Palm Elementary School in Beaumont, California. It was fourth grade, and what was going on in the classroom was beyond my attention. That's because my mind had escaped. Looking out the window was my only escape from the endless monotony of the classroom.

Being "jerked back" when the teacher called on me, was overwhelming and nauseating. I felt I had missed so much while being "spaced out" that the demands seemed insurmountable. I had no clue where to begin.

Since I felt little hope of being rewarded for my feeble efforts, my biggest desire was to escape on another mental vacation. That is exactly what I did. My mind traveled out the window again — even though I dimly knew that I was digging myself into a deeper hole. As self-defeating as this strategy was, it was my only defense.

My understanding of Attention Deficit Hyperactivity Disorder is deeply rooted in my own experience. I was an ADHD child. I am now a Ph.D. Clinical Psychologist with a thriving and successful practice.

Parents, there is hope for you and your ADHD child.

Why My Interest in ADHD

Professionally, I have been working with ADHD children since 1971. For the first twenty years I read the books, took courses, and did the therapy as prescribed. As hard as I tried to make it work, the theoretical picture did not seem to fit the children I was seeing, nor did the prescribed therapy approaches prove very useful.

In 1991, I began to develop a radically different approach to psychotherapy for all of my patients, ADHD and others. This led to the invention of a computerized psychotherapy machine, Computer Aided Emotional Restructuring (CAER).

Computer Aided Emotional Restructuring is a new, patented, treatment that sprang from another new therapy, Eye Movement Desensitization and Reprocessing (EMD/R). (EMD/R is fully explained in chapter 24).

Unlike traditional therapies, CAER does not depend much on talking. Rather, it taps powerful neurological mechanisms to elicit deep relaxation and vivid mental imagery. When these two effects are juxtaposed, pathology-producing emotions are extinguished through a process called desensitization.

More simply put, CAER uses lights and sound to help the ADHD child enter a relaxed state. Then, the relaxed and calm child, with the aid and supervision of a therapist, imagines an anxiety-provoking situation — such as school. Quickly, the relaxed state erases the anxiety state so that school, or whatever the provoker might be, no longer causes stress in the child.

No drugs are used at all.

Initially I used Computer Aided Emotional Restructuring on my adult patients who had a variety of common problems such as depression, anxiety, phobias and marriage problems. The results were exciting. Many times these problems were eradicated in just a few sessions.

Therefore, I began to extend the procedure to other problems not commonly addressed by EMD/R, including ADHD. Even with my early, primitive CAER machines, the results were striking.

I really did not know why CAER works, but two different sources began to yield insights. By reflecting on my own difficult school history and listening to the ADHD children

themselves, my understanding developed. These children were telling me about feelings and experiences that I could remember well from my own school years.

That's why ADHD: A Path to Success is a story of hope for parents of ADHD children. It is a personal story. It is my story. It is the success story of my patients.

Traditional View	My View
ADHD Children are defective and disabled.	ADHD is a very refined adaptive skill
There may be neurological problems in ADHD children.	Neurological problems are irrelevant because ADHD is learned.
An ADHD Child's mental processes are strange, unusual or defective.	ADHD children think just like we do.
Ritalin improves children's performance.	Ritalin helps parents and teachers, not children.



When people describe a specific ADHD child, I'm often left with an image of the kid with a clock mainspring spiraling out of his head and gears raining down. If all of his gears and springs were in right, if his broken parts were fixed, he would work and do what we want.

ADHD children are not clocks with a broken mainspring and gears falling out.

In fact, we do treat the child as if he were a broken mechanical device like a watch. But we use professional words such as "disorder."

We do this because a medical diagnosis denoting disorder, brokenness, or deviancy makes ADHD more socially acceptable. As neat and circumscribed as this approach seems, it does not capture the diffuse, culturally enmeshed nature of the problem.

In truth, the ADHD child does not have a "disorder." He is not broken.

He has just learned adaptive strategies that we do not like. He resorts to ADHD behavior, not because his gears and springs are not meshing, but because it works, and it works well. The gears of an ADHD child mesh with perfect precision, expertly propelling him away from his discomforts.

We, as parents and teachers, just happen to find his strategy in conflict with our own agendas. Simply put, we think if you are not like me or do not do what I want, you are deviant or disordered. Thus, I am order; you, disorder. This is incorrect thinking.

The ADHD child is a highly trained and skilled adapter to a painful situation. The mechanisms that he uses are exactly the ones the rest of us use on a daily basis. However, within the closed, repetitive conditioning situation of schools, these adaptive strategies are exaggerated and ultimately backfire.

* Names and identifying characteristics have been changed to protect identity.

Chapter 1

ADHD _ Adaptive, Not Defective

Chris, a Six-Year-Old Boy with Attention Deficit Hyperactivity Disorder

Chris* was a cute, freckle-faced, six-year-old boy who embodied my image of Tom Sawyer. Only in the first grade, Chris was already falling behind in his schoolwork. His teacher described him as constantly disrupting the class by speaking out of turn, touching other children, being out of his seat, and playing with toys rather than doing his work. Occasionally Chris would get into fistfights with other children. He did not start such conflicts, but when provoked, Chris spared no effort or tactic to win. And he always did win.

Chris' mother brought this young "Tom Sawyer" to me for an evaluation for Attention Deficit Hyperactivity Disorder (ADHD). This was at the school's insistence. The teacher was resolute in her belief that Chris had ADHD and must be put on stimulant medication.

Since Chris' mother strongly objected to this recommendation, she instead brought Chris to me, a psychologist with a new, drug-free, alternative treatment.

After only three sessions using Computer Aided Emotional Restructuring (CAER), Chris' behavior at school and home improved markedly. Yet at age six, Chris was at the lower limit developmentally to benefit from CAER.

Three years after his initial visit, follow-up evaluations have revealed no further academic or behavior problems. Chris is still doing well at home and school.

If you know anything about traditional psychotherapy or theories of ADHD, the best thing you can do is forget it for now. Goethe said it well: "It is impossible to learn something you think you already know." So for now, getting dumb is the most brilliant thing you can do.

Computer Aided Emotional Restructuring is a treatment technology that extinguishes ineffective emotional patterns quickly, effectively, and without drugs.

As the title implies, "emotional restructuring" demands cooperation from the patient in order to dredge up unpleasant memories. These unpleasant memories are often the root of physiological and psychological problems.

With Chris, I asked him to think about people who made him mad. This included his teacher, some of his fellow students at school, some boys at day care who would not let him play, and his big brother. Chris liked doing this. He said it made him "think about things."

At the end of session one, which included an initial evaluation and beginning treatment using CAER, Chris' mother was given a five-minute cassette tape and instruction sheet to take to the teacher.

During sessions two and three using CAER, this same tape was played. Once again, Chris was asked to think about people who made him angry. He reported that this tape made him mad. He also said that after he had listened to the tape a few times, it did not make him angry.

By the end of the third session, Chris did not seem to have any emotional response to the tape. The powerful feelings that were at the root of Chris' behavioral problems were extinguished by CAER.

I also saw Chris' mother for one session. This was to alleviate her own guilt about putting firm limits on her son. Abused and rejected in her own childhood, she was overreacting in her determination to avoid the same patterns with Chris.

Although she had an excellent command of behavior management concepts, she could not effectively put them into practice because doing so made her feel terrible. In fact, whenever she tried to be firm with Chris, his complaining made her feel like the "Wicked Witch of the West."

After one session using CAER to re-experience her own unsettling emotions, Chris' mother was able to do an excellent job of systematically rewarding and punishing Chris. That's because such actions no longer tapped into her own emotional history.

With the help of CAER, ADHD can be overcome.

ADHD Demographics

ADHD is a major problem occurring in as many as 3.5 million children in the United States, or three to seven percent of the nation's children, according to various estimates. No one really knows the exact number. The male-to-female ratio is about two to one.

Its common characteristics are:

- 1) Fidgeting with the hands or feet
- 2) Difficulty remaining seated
- 3) Difficulty awaiting taking turns in games
- 4) Difficulty following through on instructions
- 5) Shifting from one uncompleted task to another
- 6) Difficulty playing quietly
- 7) Interrupting conversations and intruding into other children's games
- 8) Appearing to not be listening to what is being said
- 9) Doing things that are dangerous without thinking about the consequences

Currently ADHD is thought of as a neurological disorder that affects motivational systems. Accepted treatment consists of behavior therapy and/or stimulant drugs.

These treatments are usually helpful, but the child's behavior seldom becomes normal. When either of these treatments is withdrawn, behavior most often regresses.

That's because the treatments only manage and do not cure the pathology (Barkley, 1990).

Myths of ADHD

Traditional thoughts about ADHD impose a number of damaging myths onto children like Ryan. These myths have led to many ineffective approaches for treating ADHD.

Let's compare traditional views of ADHD with my view of children like Ryan.

Chapter 2

ADHD: Historical Change in Labeling the Disorder

Luke, a 14-Year-Old ADHD Boy

Luke was a recalcitrant bully who had struggled with both behavior and learning problems since his earliest school days. In fact, his academic performance was in the barely passing range.

When Luke hit third grade, he was referred to a pediatrician, who diagnosed him as ADHD and began treating Luke with Ritalin. The effect of the stimulant was immediately positive, and Luke's parents thought the problem was solved.

But in less than a year, his behavior and grades again began to decline. Over the next several years, his parents and doctor tried a variety of behavioral approaches. At the same time, they were periodically putting him on and taking him off his stimulant medications. Nothing seemed to work and the family frustration level rose.

By the time the family arrived in my office, Luke had been thrown out of two schools and was temporarily expelled from his current school. His records indicated that he had at one time or other carried diagnosis of ADHD, BD, and LD. He was covering his embarrassment about his poor academic showing by fighting with his classmates. He took pride in the fear he provoked in his peers.

He also turned his intimidation skills on his mother, who was particularly vulnerable to his tactics because of her chronic and occasionally severe depression.

I had Luke make emotionally provocative audio tapes for each of his parents, and they jointly made one for him. Luke then spent seven sessions on CAER reviewing the tape his parents had made as well as his anxious, frustrating, angry and demeaning academic experiences.

He remembered the times he was laughed at in class, when teachers were mad at him, when he felt like a failure, as well as when his peers made him angry and hurt his feelings. As these feelings abated, his behavior at home and school improved.

At this point, though both parents were involved in Luke's therapy, the focus turned to mother and son and dealing with the emotional history that caused Luke's mother's depression and Luke's academic anxiety and anger.

Luke's mother spent six CAER sessions reviewing her background of neglect and abuse, which laid beneath her depression. As her depression lifted, she became better able to administer systematic discipline for Luke's antics without caving in or feeling guilty. To her surprise, as she became firmer and more consistent with Luke, he respected her more, wanted to spend more time with her, and became more compliant.

Luke's father spent three sessions extinguishing the resentments toward his wife that kept him from being a fully cooperative parent, as well as the resentment that he had built up toward Luke for all the years of family uproar he had caused. These emotional changes led him to be a more supportive husband and a more engaged father.

After Luke, his mother, and his father had all taken their turns in the CAER machine, extinguishing their responses to the tapes, the family conflict was minimal, and Luke now gets B's and C's with little effort. He is no longer a bully at home or school.

Three-year follow-up indicates that these changes are stable. Luke is now in his senior year of high school. He plans to attend the community college next year. His mother has had no reoccurrence of depression. His mom and dad are finding more things to share and spend more time together.

ADHD, Current State of the Art Debunked

Numerous names have been given to the learning and behavioral problems that are common in children today. These labels represent non-distinct, overlapping categories that are often used as much on the basis of current popularity or the availability of funding as on the characteristics of the child.

Because of this, many children carry multiple labels, either at the same time or across time. The three most common labels used today are Attention Deficit Hyperactivity Disorder (ADHD), Learning Disabilities, and Behavior Disabilities.

Since categorization and diagnostic efforts have primarily focused on describing and measuring the alleged differences between these types of children's problems, there has been little interest in understanding the predominant commonalities they share. Yet, they are simply variations of the same theme, and they are far more alike than different.

Therefore, my efforts have been directed toward understanding the common forces that drive children who carry any of these three diagnoses and finding effective treatment for the shared patterns — contrary to the interests of most investigators in this area. And since ADHD is the most inclusive of the three disorders, the following discussion begins with it and then shows the relationship to Learning Disabilities and Behavior Disabilities.

History of ADHD Labeling and Treatment

Over the years, numerous labels have been given to children with ADHD. In the 1960s they were called brats. With the growing medicalization of common problems, they were labeled Minimal Brain Dysfunction. As behaviorism became popular, they were called hyperactive. Eventually these children were labeled Attention Deficit Disorder, or ADD.

From the last two labels evolved the currently accepted diagnosis of Attention Deficit Hyperactivity Disorder, ADHD. There seemed to be something curative about finding exactly the right name for these troubled children.

ADHD was originally thought of as a neurological disorder that damaged a child's ability to focus his attention. During the 1970s, stimuli of the outside world were seen as involuntarily intruding into the patient's consciousness, similar to how delusions intrude into a schizophrenic's consciousness.

These children were thought to be unable to filter out unwanted intrusions. Their attention was dragged to and fro by whatever surrounded them. In other words, children were helpless victims of environmental stimuli.

Treatment during this era consisted in part of placing the child into a low-distraction environment — such as a quiet study booth with nothing on the walls. Classrooms with high or few windows were built. The idea was to reduce the number of potential distractions that might lure the child from the desired task.

This approach went through its placebo-effect period of success. With increasing experience, however, the placebo effect wore off, and windowless rooms did not seem to be of much help. In moments of desperation, though, this treatment is still occasionally used.

Treatment efforts were then directed toward teaching children to "control themselves," meaning control their own attention levels. The idea was that the children lacked the skills to control their own wandering minds.

Since this was a nice philosophical fit with the educational setting in which most of the children were identified and treated, an action plan was easily developed. Children were taught cognitive behavior therapy techniques.

This means they were taught to think differently about problems and to talk to themselves in special ways, ways that would help them make "better choices" — as if the children had chosen to be ADHD in the first place.

In a recent consultation with school staffers of an ADHD child I was treating, I was struck by what the principal said. She proudly explained in detail that whenever Brandon, the ADHD child in question, misbehaved, she would take him into her office and "go over what choices he had and each of their consequences."

What Brandon really got was the undivided attention of the highest status person in the school, in the highest status room in the school.

The principal, counselor, and teacher attending this meeting were so entrenched in their educational/cognitive model that they were completely unaware of the powerful social reinforcement they were providing Brandon for his rather minor acting out behavior.

Bewildered, they could not see why such a rational, logical approach was not working. They could not see the obvious because it lay outside their favored cognitive model.

Cognitive behavior therapy or this "teach the child to think differently" therapy, is still quite prevalent in school-based treatment efforts because it fits philosophically with school administrators, counselors and teachers. Today, teachers still ask children "Why did you do it?" referring to "bad choices," and want the ADHD students to "learn new skills."

Research on cognitive strategies do show some short-term benefits, but the gains fade quickly.

More recently, the notion of distractions intruding on the ADHD child's consciousness is no longer postulated.

ADHD is viewed, instead, as a motivational disorder characterized by quick boredom with rewards (Barkley, 1991). In other words, the child is so easily bored with his reinforcers that he has difficulty focusing his attention on the current activity. This boredom causes the child to search his world for alternative, novel, reinforcing stimuli.

From the child's perspective, seeking alternative stimulus is viewed as an active, adaptive strategy, despite the fact that it is often in conflict with his environment. For our

purposes, viewing the child as an active agent versus a passive victim is critical to our understanding. Nintendo's Mario points up the fallacy of the theory that the strength of reinforcers fades. More on that later.

Chapter 3

A Personal Experience of ADHD

Understanding ADHD Thought Process

In order to better understand ADHD, it is imperative to see the ways in which our common, daily experiences are similar to the thinking, feeling, and behavior of an ADHD child. This is important for two reasons.

First, regardless of whether you are a teacher, parent, or researcher, little can be gained until you begin to see the world through the eyes of an ADHD child. Invaluable insights are acquired by mapping the experience of a child through our own personal experience. Formal research experiments can only validate, not originate, these insights.

Secondly, by personalizing the experiences of the ADHD child, we make an important discovery. This discovery flies in the face of traditional medicine, which wants to identify something as broken and fix it, i.e., medicate it.

This discovery, which supports one of my major tenets, is inescapable. This discovery is that ADHD children think the same way we do. Their situation has just trained them to emphasize certain thought patterns more than others. And we use exactly those same thought patterns on a regular basis, just not as often as the ADHD child. In fact, most of us would resort to the same strategies if we were put in the same situation as the ADHD child.

But because we think of ADHD children as being different, because we think they have a "disability," we refuse to give ourselves the same disability label — despite the exact same thinking style.

Yet, ADHD children think no differently than we do.

We Think Like ADHD Children All the Time

Let me illustrate by citing a personal experience. While engaged in the relentless drudgery of writing the computer program logic and voice prompts for CAER, I was having trouble concentrating. My attention constantly drifted off after I wrote each sentence. I continually caught myself looking out the window, going to the bathroom, making a telephone call, or looking at a magazine.

With great effort, I brought myself back to the tedious, repetitive task at hand — writing another sentence. A large cup of espresso coffee helped increase my willful control over my attention. With the coffee, I temporarily regained the power to make my mind do the required task for a little longer.

Finally, after hours of this struggle, I logged onto the Internet. In just a few seconds, my attention and energy improved dramatically, though I had not changed my position at the very same computer, the very same desk, next to the very same window.

My attention went unbroken for the next hour as I searched the Internet for things that interested me.

Thinking back over this scenario, I see my experience exactly parallels that of the ADHD child. I was forcing myself to do a dreaded task, much as a teacher forces a child to do his work in the classroom.

My writing the computer system was very similar to the ADHD child doing math or spelling. Both of our tasks required continuous, sequential attention to detail. Both were repetitive of a similar process with detailed variations. Both were boring because of the repetition, and both of us were required to do the task to achieve a goal.

Though I could keep my body at the task just as the teacher keeps the child at his desk, the unpleasantness of both our tasks soon conditioned our attention to switch to more interesting things. For the child it might be staring out the window, playing with an eraser, talking to a friend in the next row, or wandering around the classroom. For me, it was staring out the window, making a phone call, and reading a magazine.

We both achieved relief from these boring tasks by automatically, against my conscious intention or the teacher's will, learning to avoid the aversive tasks by shifting our attention away from them — "spacing out" or becoming distracted. Relative to the tasks assigned to us, we each had an "attention" deficit and were being "hyperactive."

In fact, my cup of espresso worked just like the child's dose of Ritalin (or Dexedrine or Cylert). Ritalin allows the child to focus his attention on his work in order to please his teacher. Caffeine helps me to force my mind to do what I want it to do, as opposed to helplessly following my learned defense patterns and not performing a tedious task that I don't want to do.

Both Ritalin and caffeine help us redirect our attention back to the task we intentionally wish to address. Both Ritalin and caffeine are powerful central nervous system stimulants.

(As a sidelight, before stimulant drugs came into widespread use, mothers of ADHD children discovered that a cup or two of coffee in the morning would help their youngsters survive the morning hours in school.)

My time on the Internet also worked like a child's time on Nintendo. As many parents know, ADHD children can attend to Nintendo for hours, even though they may have been very distracted from the school work that immediately preceded it. My ability to focus my attention rebounded in exactly the same way when I logged on to the Internet.

The Internet and Nintendo share a common feature in that they have no negative history that make a person want to "space out" instead of doing the needed work. At our chosen tasks our attention was flawless. It would seem to take a very peculiar neurological deficit to account for such sudden variation in both of our attentional patterns.

Do I have ADHD? I doubt it as much as I doubt that most kids labeled as such have ADHD, at least as it is normally conceptualized as a neurological disorder. We have to give up the idea that the ADHD child's mental processes are strange, unusual, defective or inferior. They are just one more variation of the perceptual distortion that all of us use everyday to survive in an often-crazy world.

Your Personal Experience of ADHD

One way Zen masters teach meditation is through painting. But before a Zen master will let you paint a flower, he insists that you become the flower.

You must meditate on it until you no longer just see it. You must experience it and know it as part of you. Only after you understand the flower in that depth, does the Zen master believe can you meaningfully paint the flower.

This is even truer when you are trying to "paint" the transient nature of attention. Not only is cognitive understanding not enough, it is, in fact, not even useful.

Let us try an experiment that will help us move beyond a mere intellectual understanding of the distractibility of an ADHD child.

Stop reading now and think back over your own experience of having to do some boring, repetitive task for a very long time.

Remember how easy it was to space out or become distracted.

Did you ever try some coffee to help get you back on task? How did it work?

Remember how easy it was to focus your attention on other tasks that captured your interest.

Compare your attention under these two conditions — boring task vs. interesting task. If you can do this, you have walked in the ADHD child's shoes, and you have taken a major step in helping them.

Personal History of ADHD

My formal learning career started off poorly. I am told I never stopped moving. I took everything apart — a toy, a clock, or the house.

Though my teachers seemed to like me, I was always in conflict with my peers. I was a big kid, and my clumsiness put me on the short end of such fights.

My issues were not confined to school, like most kids with school and learning difficulties. I had more important things on my mind -- my parents' fighting. Thinking about their battles made it hard for me to focus on school.

Even though their fights were limited to strong words, their hostilities preoccupied my mind. My emotional arousal was too high for any real learning to take place. I was worried and anxious. These conflicts with students and parents took precedence over school. Soon I fell behind my peers.

This started a destructive chain of events. I began to get negative feedback from students and teachers. This in turn made me feel anxious when I had to answer in class or was put in any evaluative situation.

My repeated failure at academic tasks, particularly reading, sparked raw terror in me. In elementary school, we had regular reading circles.

Six or eight kids would sit around in a circle taking turns reading.

I would sit there in a cold sweat as my turn came closer and closer. It was my teacher's version of Edgar Allen Poe's "The Pit and the Pendulum." The reading blade kept coming closer and closer.

To try to save face, I would count the number of children before my turn to read and try to calculate which paragraph I would be expected to read. Then I would go over and over this paragraph trying to work out every word. I would try to memorize it because I knew I

was so anxious that there was no way I could actually read it in front of the other kids and teacher.

Despite and because of my high anxiety efforts, I usually botched even the simplest reading task. I became even more humiliated, embarrassed, angry, depressed, and degraded. I could think of few things in life worse than reading.

What was more sinister than Poe was that the reading blade did not kill you. You would have to face the reading blade the same way tomorrow, and the next day, and the next day for what seemed the rest of your life.

Several times a week a remedial reading teacher would take me and some of the other "dummies" out of the classroom for an hour or so, to practice our reading.

I was always aware of being in the "sparrow" reading group because everyone knew that it was for the dumb kids. (In spite of adult efforts, kids quickly pick up on the real facts.) And yet, I cannot remember any different procedures being used by this teacher than had been used by my regular classroom teacher.

Though her efforts were valiant and well intended, they were just another dose of the same old toxic solution that I eventually learned was the source of my problems. I made little progress.

How could I? To me, reading was associated with school, reading groups, reading out loud, peer ridicule, and poor self-image.

The harder the teacher tried, the more upset I became, the worse I did, the dumber I got. I saw this as just another opportunity to face the terror of the reading blade. I began to fight passively the very process of what felt like stuffing things down my throat. I did not learn to read until I was in the seventh grade.

Eventually, I did learn to read, not because of more sophisticated efforts by my teachers, but because I developed a driving need to know, literally. I was interested in hot rods.

I wanted to know about the most technical aspects of cam timing, fuel injection, and suspension systems.

Since no one in my world, including my car mechanic father, had an in-depth knowledge about these things, the only way to learn about them was to read.

At first, the reading was difficult. I picked through articles word by word, read captions on pictures, and guessed a lot. Despite the difficulty, I was powerfully motivated to decode this information system that held the key to what I wanted to know.

Within two weeks, I was reading well. And reading was no longer the terrifying school subject that made me feel incompetent. In fact, it was part of a world that had nothing to

do with school. It was something I did alone at home for hours, pouring over hot rod books and magazines. Alone at home, reading was easy and fun. Alone at home, it became my bridge from one world to another, simply through my urgent need to know about hot rods.

Also on my own, away from school, unbeknownst to my peers, parents or teachers, I had worked out my own simple system of trigonometry. My methods even included basic look-up tables for a variety of what I later realized were standard trig functions. This was my own private system of calculation not a trigonometry that I had learned in school. Thank goodness I did not even know a discipline of trigonometry existed. If I had made the association with math in school, likely this calculation system would have been stymied by the transfer of negative emotions from school.

Rather than this calculation system coming out of school assignments, it rose out of a curious observation. One night while riding in the back seat of my parent's car-watching search lights bounce off of a low cloud ceiling. I wanted to figure out a way to determine how high the clouds were by measuring the angle of the searchlight and the distance between the searchlight and the spot directly under where the light bounced off the cloud. It was a very practical concern, not a math homework problem that drove my thinking. The first round of calculation was on the fog on the back window of my parent's car. Thank goodness it was a large back window. That happened when I was in the fifth grade.

My newly acquired skills also began to have payoffs outside my bedroom. The formerly dumb kid now had the keys to unlock the rest of the school tasks. Those were the days of Evelyn Woods teaching JFK speed reading, and I became adept at speed-reading. By the end of high school, I had become the fastest reader in the school. This did not mean that all academic hurdles had been solved with one fell swoop, but a giant step had been made. I was easily getting A's and B's, but I still felt like the dumb kid.

I am sure Mr. Hurd, my 8th grade English teacher would have been shocked by my improved grades. In order to take Spanish in high school I had to get permission from Mr. Hurd. When I presented him with the form to sign he took me to a large cloak area in back of the classroom so we could talk privately. I will always remember what he said, "I will sign this because you are a nice kid. But, as soon as it gets too hard, drop it. If you work hard we think you can graduate from high school." Then he signed the form. I was hurt, angry, determined, and confused. A sense of determination welled in me, and stayed with me for years there after. I would show him.

To you, Mr. Hurd, it is "Doctor Weathers."

I only went to college because a high school counselor noticed I was getting good grades and called me into his office. When he suggested that I consider going to college, I had no idea where to find one. I was so naive about education that I was shocked when, during my junior year of high school, the school superintendent got his doctorate and

then did not open an office to practice medicine. I didn't know there were any people other than physicians who had the title of doctor.

Despite the gains, despite the fact that I now have my own doctorate degree and am called Dr. Weathers, the scars from the reading circle are still within. To this day, I avoid reading aloud if at all possible. But reading and trig were exciting mental adventures for me. And these isolated contemplations were to me what Nintendo is to the current crop of ADHD kids.

Like Nintendo, my trig and reading about hot rods had no relationship to my failure experiences. There was no negative learning history associated with them. Without the anxiety, I could learn quickly. In a similar way, the treatment proposed in this book, CAER, extinguishes the anxiety, so that formerly ADHD children can learn easily.

Chapter 4

The Conditioned Attentional Avoidance Loop Model

Developmental Vulnerability to Family Conflict and ADHD

Clinically, ADHD children appear to be exposed to many and sometimes severe early stresses. In fact, in the hundreds of families I have worked with, I have seldom found an ADHD child from a family that did not have a history of problems.

Marital conflict, parental illness, divorce, economic strife, verbal or physical abuse, or one of many other things are often the stressors. Few of these ADHD children seem to come from stable "Leave it to Beaver" families. This may be one reason why twice as many boys as girls have ADHD. Boys develop more slowly, so more of them would be ill-prepared to cope with such problems. And being forced to deal with such early stresses shapes the child's ability to focus his attention.

In other words, since the child is forced to deal with disturbing stimuli in an unpleasant environment, he develops a preferred, attentional style

— he avoids the unpleasant by focusing his attention elsewhere.

This is called attentional avoidance ... the Conditioned Attentional Avoidance Loop.

Conditioned Attentional Avoidance Loop Model

The Conditioned Attentional Avoidance Loop Model hypothesizes that ADHD behavior could be a result of a child's exposure to interpersonal stress before the child is developmentally equipped to handle it.

Indeed, attentional avoidance may be the only mechanism for a young child to escape these early stresses, since their physical mobility to escape is restricted and they do not have the verbal or intellectual skills to change the stressor.

Once this adaptive strategy garners some negative reinforcement, it is refined and resorted to more and more frequently. When the stresses of school arrive, the child has a well-refined escape mechanism to deal with the new demands. It works well for young children and we call it ADHD.

According to the Conditioned Attentional Avoidance Loop Model, ADHD children avoid negative emotional experiences and direct their attention elsewhere via anger, performance anxiety, social deprecation, frustration, and ultimately boredom.

They do this much like a baby turning its head away from something it does not like. Thus, ADHD is not a deficit, defect, or deficiency. It is a highly skilled, coping mechanism that, at the moment, serves the child.

The thought of doing math makes him angry and depressed, feelings he would just as soon avoid. Although he dislikes the feelings he experiences during math class, he cannot physically avoid being in math class every day. He finds that if he fantasizes about skateboarding, being in math class does not feel as bad.

PAIN-FREE MATH CLASS

Over time, due to negative reinforcement, he learns to fantasize sooner, better, and more automatically. He effectively develops greater protection from the feelings he used to get from math class.

Negative reinforcement is an often-misunderstood concept. Unlike common usage, it is not equivalent to punishment. It is like lying on the beach in the sun until you are very hot and



uncomfortable, then terminating this aversive overheating, by getting in the cold water. This temperature change is experienced as positive change. This positive feeling of cooling off thereby reinforces dunking in the water when you have become too hot.

Therefore, negative reinforcement is the cessation of aversive stimuli, which by contrast to the aversion, is experienced as a positive or reinforcing change.

There are at least two other positive feedback loops that further exacerbate this process of learned attentional avoidance.

First, the refinement of attentional avoidance further reduces a child's awareness of, and participation in, schoolwork. The child eventually begins to slip involuntarily into conditioned attentional avoidance and, as a result, he spends more and more time in his "own little world."

Second, the teacher is shaped into being more demanding and coercive through negative reinforcement because of the short-term positive benefit of such efforts. This short-term success shapes increasing long-term negativity in the teacher.

The first process works like this:

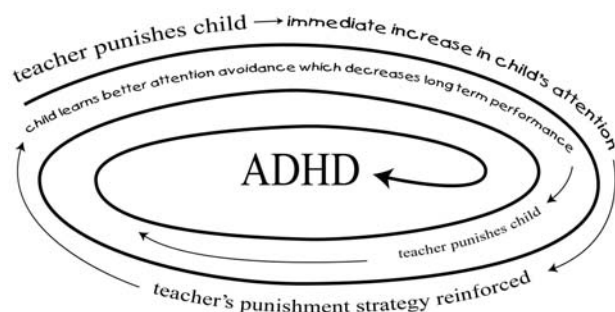
As the teacher becomes more determined and insistent that the child do his work "or else," the experience of being in school becomes more negative to the child. So any mental escape he manages (and he will escape many times) is even more negatively reinforcing than it had been previously. That's because it affords successful escape from an increasingly noxious situation.

Second, this negative reinforcement teaches faster and stronger attentional avoidance so that, next time, the teacher must be even more demanding to get the same result.

The escalation of the teacher trying to control the child and the decreasing functioning of the ADHD child is a regularly observed pattern in school settings. Yet, the cause and effect relationship between these two sets of behaviors is not generally understood.

In summary, the ADHD child's decreasing performance elicits more negative feedback from the teacher. The more negative feedback used by the teacher to exact (temporary) compliance and improved performance, the more negative reinforcement the child has for learning more effective attentional avoidance skills. The child is then in a downward spiral that feeds on itself.

There is also a more general and damaging level of conditioning going on with the ADHD child.



With practice, the child learns to detect, earlier and earlier, links in the chain of events that typically lead to the aversive situation, such as a math assignment.

By sensing and reading the cues earlier and earlier — in fact, even before the original problem shows itself — the escape trigger is pulled sooner and an increasing portion of the child's world is subject to involuntary, conditioned attentional avoidance. He automatically "checks out" in a wider variety of situations as time goes on.

Continuing the above example, the child now learns to avoid not only math but also the math book, math homework sheets, the math teacher who gives him these materials, and the math classroom.

Bottom line — his avoidance coping mechanism is being triggered by a multitude of stimuli, which makes him mentally absent more often, in fact, most of the time, which, in turn, makes his performance deteriorate further.

Children's Limited View of Time

For all of us, immediate rewards and punishments rule our behaviors more than distant gratifications and retributions. Therefore, the arrangement of events in time is critical to development of ADHD.

Take the drinker, for example. At the party last night, the alcohol relaxed him, made him feel more social, and generally made the evening more fun. The reinforcers for drinking were significant and immediate.

The next morning, he had a hangover with dry cottonmouth, a headache, the sensation of cotton candy for brains, and a roiling stomach. The next morning, he felt miserable. But that was many hours after the behavior of drinking, so it had little effect on the drinking behavior.

How many people would drink if they got the hangover first, immediately after drinking, and the next morning they felt great? Not many. Next morning's good feelings would be so remote that they would be unlikely to reinforce drinking. But the close proximity of drinking and the hangover would likely suppress drinking.

When the temporal sequence of the same reinforcers and punishers is changed, the effect on the behavior they follow also changes. For young children, this effect is exaggerated, which makes them particularly vulnerable to certain contingencies.

Young children view time quite differently than adults. At the developmental stage between the ages of five and nine, when children are most often developing ADHD, the idea of long-term consequences has little meaning to them. Next week is as far away as next year. Managing the aversiveness of experience here and now is all that matters.

Thus, the fact that their attentional avoidance strategies are eventually going to be very costly to them is meaningless.

Attentional patterns leading to ADHD are likely to begin to form long before adults in the child's world begin to notice them. Once the child discovers attentional escape and negative reinforcement they tend to continue.

These attentionally avoidant patterns work when they are first learned and continue to work long after they should have been replaced with more effective strategies. It is difficult for the child to give up something that has worked so well for so long.

At this developmental stage, children are very responsive to short-term rewards and thereby more vulnerable to problems like ADHD that are shaped by an emphasis on short-term contingencies. They are not developmentally ready to use the thinking patterns, i.e., choices that we attempt to impose on them.

Avoidance Conditioning: The Horse Grows Bigger

Avoidance conditioning in children is similar to adult phobic behavior. For example, consider the behavior of the patient who has a horse phobia. The more successful he is at avoiding horses, the more he feels compelled to avoid them.

For the phobic person, being thrown off a horse may have started out as only mildly anxiety producing. As the actual experience gets more remote because of successful avoidance of horses, the memory of being thrown off the horse gets progressively worse. The recall experience elicits more and more fear than the original experience did.

This increased aversiveness of the memory of being around horses makes it more reinforcing to successfully avoid horses, which in turn makes being around horses more fearful, and so on so that a vicious circle develops.

The exact same process unfolds with the regard to the ADHD child.

What was initially a mildly aversive school situation becomes successively more disturbing after many opportunities for successful avoidance. The ADHD child may have started out mildly frustrated or anxious in math class, but after successfully spacing out in class for a while, the remembered experience of math class may be worse than the previously experienced reality of it. It is like being thrown off a horse.

Folk wisdom tells us to climb immediately back on the horse before fear has a chance to grow. And that folk wisdom is very accurate.

Computer Aided Emotional Restructuring provides an efficient psychological tool to climb back on the math horse. At first, the CAER ride on the math horse is emotionally

evocative, just like climbing back on a real horse might be. Children often express anger, fear, anxiety, and depression as they mentally re-experience their academic phobias.

But CAER makes it much easier to stay in the saddle until the emotional bucking stops and the scary math beast is tamed and finally becomes emotionally flat.

Chapter 5

ADHD: A Defense Mechanism

Bob, a 14-Year-Old ADHD Boy

Bob, a 14-year-old, was treated for ADHD in three sessions, totaling five hours. Two two-hour sessions were provided because the family lived in a distant rural town.

During Bob's first 30-minute session using CAER, he focused on all the situations that precipitated a "funny feeling in his stomach." He believed this feeling occurred just before he began to lose attention and started disrupting the class. He worked diligently on this subjective experience and systematically extinguished it.

The father, who brought Bob to the therapy sessions, was just as diligent and cooperative. He was given two five-minute cassette tapes. One was for his wife and him to record statements that provoked Bob, the other was for Bob's teacher to do likewise.

Because of bad weather and the long distance, the second session was three weeks after the first, but it was two hours long. At that time,

Bob and his father already reported significant changes at home and school.

During that second session, Bob listened repeatedly to the two tapes his parents and teacher had recorded. His initial response to each tape was anger and agitation. This faded to boredom after a few repetitions.

I also used part of the second session to put the father on CAER to extinguish his emotional responses to Bob's provocative behavior.

By the third session there were few behavioral problems left to work on. Bob's behavior was dramatically better, his grades had improved sharply, and his mood was more positive. So in that session, Bob focused on his performance anxiety in academic work and social situations.

ADHD as a Defense Mechanism

The Conditioned Attentional Avoidance Loop Model appears to be radically different, but in actuality it is a logical extension of traditional theories of psychopathology.

Traditional theories, despite their differences, embrace Sigmund Freud's notion that psychopathology is the result of an earlier emotional trauma. The adaptation to that trauma results in the psychopathology.

ADHD works by the same processes and serves the same function as traditional psychological defense mechanisms. In fact, it is best thought of as a defense mechanism favored by children.

Freud talked about how repression, suppression, or denial, are ways of keeping noxious thoughts and memories out of one's consciousness. That is, they are attentional avoidance mechanisms that work just like ADHD.

Freud saw defenses as the patient's active efforts to adapt, but that ultimately, if overused, backfired. So too, it is with ADHD. Framed in terms of Conditioned Attentional Avoidance Loop Model, the patient is as an active, skilled adapter to the environmental stimuli, just as Freud saw his patients. However, in both cases, defense mechanisms have gone awry.

Like all defense mechanisms, avoidance behavior functions as a way to spare the ADHD child the unpleasant emotions — whether they are triggered by internal or external experiences. It does this by keeping annoyances out of consciousness. But the defense strategy suggested by the Conditioned Attentional Avoidance Loop Model is more obvious than traditional defenses since:

- 1) The behavior of children is less sophisticated and thus more obvious.
- 2) The noxious stimuli (parents, teachers, and schoolwork) are usually here and now as opposed to in the past or far away.
- 3) Adults are actively engaged in keeping the child from physically escaping.
- 4) Much to the chagrin of the observing or diagnosing adult, the defense mechanisms of the ADHD child are often a reaction to the adult.

ADHD is Felt as an Insult by Adults.

This last point deserves further discussion.

My perspective using the Conditioned Attentional Avoidance Loop Model allows me to focus not only on the ADHD child but also on the adults who play an important role in his environment.

Failure to consider the role of adults in the child's world has made it difficult to observe accurately and understand ADHD. That's because the role of the controlling and evaluating adult, whether teacher or parent, is crucial to filling out our picture of the child. The adult is part of the Conditioned Attentional Avoidance Loop and the adult is the one responsible for triggering the attentional avoidance.

The child, simply, is always maneuvering to stay out of reach, and he does this by directing his attention elsewhere. No matter what you ask him, you get evasive, escapist responses — "I don't know," "Doesn't bother me," "Sure, I have lots of friends," or "I don't care."

These responses occur between bouts of looking away, fiddling with things, wandering off mid-conversation, outpouring emotionally, grimacing, or glowering. These responses are an efficient smokescreen that is both difficult and frustrating for the adult to comprehend and respond to rationally.

Seeing the role of the adult as causal to ADHD behavior may at first feel upsetting and disorienting. We do not like to think of ourselves as the target of someone else's defense system. The message received is that the ADHD child is defining you as the enemy whether you like it or not.

This differs from traditional psychology that deals with patients who are defending against some internal or historical experience. The latter is much less aversive than when someone is defending against you. Despite his most caring and benevolent efforts, the ADHD child blots the therapist, parent or teacher out of his or her reality.

In fact, it is the nature of the ADHD child to refuse to connect interpersonally with you or conform to your demands. He does not seem to understand that you are trying to act in his best interests. Instead, suddenly, the adult is on the receiving end of rudeness, rejection, or insults.

Since the adult feels helpless and frustrated in controlling the child's behavior, he or she feels personally affronted. It is as if your well-meant offer of friendship is being rebuffed.

Because of this affront to you and your reality, it's easy to see ADHD children as more defective than they are. Thus, it becomes even more tempting to categorize ADHD children in an unbecoming fashion — as we are likely to do to anyone who rejects us. If the ADHD child does not like us, he must have something wrong with his brain. So we come up with labels like "Minimal Brain Dysfunction" or "neurotransmitter hypothesis," depending on what is in vogue.

While teachers and counselors insist that they are professionals and thereby do not react emotionally to the antics of children, inevitably they do respond. Not to acknowledge this emotional reaction is to blind ourselves to a major piece of the dynamics driving ADHD. We have been seduced into focusing on only one part of the feedback loop—the child.

Jane, a 14-Year-Old ADHD Girl

Jane, a 14-year-old, white female with ADHD, had been adopted at about 18 months. Her life before adoption was largely unknown except that her birth parents were alcohol and drug abusers. Despite this, she exhibited no evidence of Fetal Alcohol Syndrome.

Jane had a long history of treatment beginning in second grade. A wide variety of stimulant medications as well as a Chlonadine patch had been tried unsuccessfully. She also had been taken to numerous psychologists and other professionals to no avail. In spite of the efforts of these professionals, private sector, as well as a special education placement in the public schools, her behavior progressively worsened.

During Jane's first appointment with me, her behavior, although joking and playful, was loud and confrontational. She made her distaste for adults very clear. She wandered around, talked constantly, interrupted others, moved objects, and cussed. Her dress and behavior had a strong masculine demeanor.

On a daily basis, her school life was punctuated by open verbal and physical conflict. Being exceptionally strong for her age, she took delight in literally bouncing other boys and girls off the lockers at school. With minimum provocation, she would regularly stand up in class and tell off the school staff with a well-developed vocabulary of expletives.

By the time she was referred to me, Jane was on the verge of being moved from her learning disabilities classes to a behavior disabilities class. Her own words pretty well summed up her situation, "My life is screwed."

Jane was certainly one of the most disturbed ADHD children I have ever seen in practice.

Our first several sessions together were focused on her anger, fear of rejection, and conflicts with peers and teachers. Because of lack of cooperation from the school, we were not able to proceed with desensitization by using tapes made by school staffers.

Her parents, though, were very cooperative, so we were able to do the desensitization tape procedure with them. By the fourth session, her parents reported that Jane showed more affectionate behavior and did homework voluntarily.

Despite the lack of cooperation from the school, by the fifth session Jane's teacher greeted the mother with praise for Jane and how well she was doing in class. At the same

time, the teacher suggested that Jane would be able to get out of the Special Ed class and into regular classes if she continued her new performance level.

Jane was not able to move into all regular classrooms because, as the ADHD subsided, her true intellectual limitations became apparent. Despite some very systematic and consistent study efforts on her part, her academic performance, though much improved, was still subnormal. Jane was mildly retarded. She has, however, been successfully mainstreamed into several classes

Though she has a somewhat odd, rambunctious, and endearing social style, it is now within normal limits. She makes friends, participates in activities, and feels good about herself. Over a three year period, Jane was treated in about 35 sessions, most of which were in the first year and a half.

She is now 17 and has not been seen for about 14 months. Follow-up telephone calls indicate that her behavior in school is normal. She is still mostly in special education classes with some mainstreaming. She has occasional minor conflicts with her parents, as is typical of most teenagers. And she is beginning to date successfully.

Chapter 6

Emotional vs. Rational Controls of Behavior

A Learning Model for ADHD: Conditioned Attentional Avoidance Loop Model

If we look at ADHD as learned behavior, and this learning produces measurable physiological changes in the child's brain, these chronic learned patterns are caused by both specific situations and broad cultural influences on the child. ADHD and the associated physiological changes in his brain are the child's adaptation to the world we have put him in, rather than being the result of traditionally hypothesized neurological defects.

The Conditioned Attentional Avoidance Loop Model Makes Neurological Theories Superfluous

There is a long and productive tradition in science to adopt the simplest, most plausible explanation for the observed data.

This tradition has been called Occam's Razor. The idea of this philosophical razor is to shave off everything that does not help explain observations. The beauty of this strategy is that it yields the simplest, most elegant explanation of one's observations.

In the case of ADHD, using Occam's Razor to shave off neurological hypotheses from Conditioned Attentional Avoidance Loop Model results in no loss of explanatory power. Conditioned Attentional Avoidance Loop Model is certainly a simpler, more parsimonious explanation of ADHD than neurologically based explanations.

The dictate of Occam's Razor is that once you have the simplest, most effective explanation for a phenomenon, you only further muddle the picture by adding logical curlicues. There is no reason to elaborate the relatively simple explanation of ADHD offered by Conditioned Attentional Avoidance Loop Model with neurological curlicues.

Conditioned Attentional Avoidance Loop Model does not rule out the claim that there is a neurological component. Such a hypothesis just does not add anything. Clinically, it is also more useful to have a theory that emphasizes variables that you can effect. Learned patterns can be changed; defective neurons can not.

First Get Run Over Emotionally, Then Learn to Run, Attentionally

Once the ADHD child is aroused by feelings of anxiety and anger, his ability to learn attentional avoidance increases while his ability to learn math, spelling and the like declines. This happens in a two-stage process.

First, the child experiences both the discomfort of the emotion as well as its negative effects on his performance. And he is overwhelmed by this experience.

Second, he learns to escape this noxious experience through attentional avoidance. Although avoidance feels better in the short run, performance at home and school soon deteriorates.

Fragile Thoughts, Powerful Emotions

The heat of such emotion easily disrupts the calm, cool, and fragile mechanism of human rationality. In fact, emotional responses are much quicker and forceful than logical responses. Emotional responses are instantaneous, whereas a logical consideration of data, options, and a decision will take at minimum a few seconds and may take years.

If the emotional response happens first, the rational response won't materialize. If the rational chain of thoughts is already in progress, it will be preempted by the mobilization of emotion.

That's why the experience of "blinking out" in an emotionally laden situation, particularly, angry confrontations, is common. In the heat of battle we're suddenly inarticulate. Later, after emotions have cooled, we have greater access to our intellectual abilities. All the things we wish we had said become obvious.

In the heat of battle, did we develop a neurological abnormality, ADHD, or a learning disability? No! No more than the ADHD child does in the classroom. Rather, our emotional arousal temporarily supplanted our intellectual process. In adults, we talk about it as "blinking out", but for children, it is a diagnosis of ADHD.

And for the ADHD child, the classroom represents the heat of battle. The Nintendo game represents performance after the emotions have cooled off. Just because a child's cognitive ability is preempted by anger or anxiety, it most certainly does not mean he has a neurological defect or disability.

Emotions and Rational Decisions

Smoking is a good adult example of how emotions subvert the most well intended rational intentions.

Everyone knows the dangers of smoking. There are frequent articles decrying smoking in all manners of periodicals. Most smokers can articulate this well. But when deep in the throes of a nicotine fit (i.e., negative emotional arousal), the smoker's rationale, knowledge, training, beliefs, intentions are overpowered by the craving for nicotine.

This desperate need for a nicotine fix drives behavior; the fragile cognitive processes don't. So the smoking goes on. The smoking persists despite the rational, mental acknowledgment that smoking is hazardous to one's health and perhaps even fatal.

These same arguments apply to other dysfunctional behaviors — such as obesity, alcoholism, child abuse, or stress.

Similarly, emotional responses also wreak havoc on the child's ability to follow through on rational intentions and agreements with others. If simple cognitive knowledge and choices do not change these negative choices in adults, how can we expect like strategies to change ADHD behavior? That is essentially what we are expecting of children when we talk to them about their "bad choices" to punch a friend, hop around the room, or not do their work.

What consequences can a child's "bad choices" have that compare with the potentially fatal choices adults make? If adults cannot control their own emotionally driven behavior, how can we expect it of children?

The only difference is power. Adults have the power to impose strategies on children. If children cannot make these ill conceived strategies work, then adults have the power to impose diagnoses on children and drug them.

Once a child is emotionally aroused by, say, a parent's words, a math book, or a teacher (as opposed to a craving for a cigarette), it is almost impossible for him to access logical abilities. The quiet and fragile insights and persuasive arguments that he has appreciated, understood, and agreed to are inaccessible because of emotional arousal. Emotions rather than reason are dictating action. This is often labeled impulsiveness and irresponsibility rather than emotionally driven behavior.

To deal with this impulsive behavior, the underlying emotions must be extinguished. Once negative emotions are extinguished, then cognitive understanding and resolve are much more likely to control behavior.

Clinically, the causal link between the anger and anxiety and the academic performance deficits are very clear. When this anger is extinguished by Computer Aided Emotional Restructuring, these children can perform as well in the classroom as in Nintendo. The child moves from a state of anger and anxiety to one of ability to attend normally — where he can access the same intellectual capabilities he possesses while playing Nintendo.

What You Say May Not be What They Hear

The lightning speed of the ADHD child's emotional responses to instructions often preempts what a parent or teacher says. The parent says, "Clean up your room." But before the parent finishes saying the word "clean," the child is furious.

That's because this interaction has a history. The child has a conditioned emotional response to the parent's voice, tone and words. That response is to his feelings of anger, rather than his parent's instruction to clean up his room. Indeed, the response is so strong that the full request is barely, if at all, heard. The child then acts on his feelings of anger, rather than the merits of the parental request.

This conditioned emotional response blocks, or at least delays, the intellectual evaluation of the instruction. This conflict and emotional arousal is difficult, not only for the adults but also for the child. Some children learn to avoid much of it, particularly in the classroom, by learning attentional avoidance of the whole experience.

Susan, an 8-Year-Old ADHD Girl

Susan was an 8-year-old, white female who had a long history of unsuccessful treatment for ADHD. This included parent training, behavior modification, and many years on Ritalin. These approaches had some short-term, positive effect. But as time passed, her behavior worsened. When I first met her in August 1992, her medication had been discontinued for several months due to its ineffectiveness.

By the time I began treating Susan, she was very agitated, hostile, antagonistic, and hyperactive. She was constantly wiggling, moving around the room, impulsively interrupting conversations, acting out with outbursts of anger, playing roughly with other children, and showing poor attention span — characterized by moving from task to task every few moments.

She constantly provoked adults around her, particularly her mother. Any comment or instruction from her mother roused Susan to explode before her mother could stop speaking. Her boredom tolerance was nominal, compliance was minimal, and she never stopped moving.

Initial treatment with CAER was difficult because of her limited attention span. Every few moments she would ask questions, sit up in the chair, or ask to do something else. Within the first treatment hour, the behavior subsided. She began to attend for five or six minutes, uninterrupted.

On succeeding sessions, she listened to a tape of her mother giving her directions, which typically provoked her misbehavior, or remembered times at school that made her angry. Initially these procedures caused strong emotional responses including yelling, grimaces, hand waving and wiggling. After several repetitions, the emotional arousal quieted to relaxation.

Susan's mother noted significant improvements at home and school by the third session. By the sixth session, no further problem behaviors could be identified. Her mother related that Susan's behavior had been very good at both school and home. She said that Susan is "calmer, minds better, attends better, and her behavior has changed 180 degrees." Her compliance with mother's requests no longer roused angry outbursts and they were often obeyed without comment. Her attention was quite normal. In a conversational setting, she now sat calmly, made continuous eye contact, and listened.

But by the end of treatment (seven sessions), Susan could attend continuously to CAER for 15 minutes or more without complaining and with no noticeable breaks in attention or superfluous bodily movement. Her general presentation was that of a normal, well-behaved child.

Watching Susan play with other children in the waiting room revealed a normal child capable of playing well, sharing toys, and sustaining interaction. Other children seemed to enjoy her too.

Her mother was also treated on CAER. The primary focus was on the ways her daughter irritated her. Treatment for the mother substantially reduced the negative reactions she had towards her daughter. Their positive interactions were greatly improved.

At four months follow-up, no regression was reported in either mother or daughter.